

YOUNG MEN AT RISK:
*An intervention to improve reproductive health knowledge, attitudes and
behaviours of young men using a peer-to-peer approach.*

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*Women's Centre of Jamaica Foundation
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Summary

In 2002, the Women Centre of Jamaica Foundation introduced a male peer educator programme in Kingston and Montego Bay as one way of expanding and strengthening the Foundation's programme for men at risk. The Foundation's programme for young men is based on the principles that young men have rights to sexual/reproductive health (SRH) information and the ignorant young males harm not only themselves but also those with whom they form relationships. Further, Disadvantaged groups often do not know where to turn and those most accessible, peers, are often not equipped with accurate information.

Twenty young male peer educators selected from youth groups, including church, in each of two communities were trained to educate their peers in reproductive health issues, to conduct outreach, refer other young men to health and social service facilities and to distribute condoms. The goal of this package of interventions was to increase contraceptive and STI/HIV/AIDS knowledge, and improve contraceptive use behaviours among young men at risk in targeted communities. In addition, the intervention was expected to positively influence male adolescents' perceptions and attitudes about the timing of first sexual intercourse and the selection of sexual partners. The programme's long-term goal was to reduce the number of new cases of sexually transmitted infections (STIs) among young men in the two parishes targeted.

A pretest/post-test quasi-experimental design was used to assess the effect of the intervention. Baseline and endline multistage random surveys were conducted (20 males from each of 25 randomly selected community and faith-based youth clubs). Condom distribution statistics kept by peer educators also provided a measure of programme effect. Observations and reflections from peer educators completed the data mix. The evaluation was limited to St. James due to practical difficulties in Kingston and St. Andrew. The final sample sizes were 420 and 144. Poor weather conditions and violence in communities served to restrict the endline sample size.

The results were mixed. Knowledge on HIV/AIDS was markedly better for the endline sample: 96 percent had correct knowledge about HIV transmission compared with 76 percent of baseline. Misconceptions regarding transmission via bathrooms, mosquito bites and kissing were greatly reduced. Knowledge of how to use the condom correctly improved over time: 96 percent of endline sample had correct knowledge of how to use a condom compared with 80 percent of baseline sample. Condom use at first sex and most recent sexual intercourse was very high at both baseline - 98.3 percent reported using a condom at first sex. Use at most recent sex (last sexual intercourse) showed a small increase - 94.4 percent and 98.7 percent of baseline and endline samples respectively. There were no changes in partner reduction behaviours.

Notwithstanding the challenges of implementing this intervention, the effect of the intervention on men in the Montego Bay community and the peer educators was sufficiently powerful to have strengthened the Foundation's resolve to continue the programme in the two parishes and also to expand the peer programme to other parishes.

I. Background to Study

Prior to the 1980s, the term “men at risk” was not part of the general vocabulary of social programmes and sociologists in Jamaica. Today, the situation is different. More and more, persons within social, political and economic institutions are referring to ‘men at risk’ and using the term ‘male marginalization’ to characterize the situation of young men in Jamaica. This shift in language and focus reflects concern for that noticeable downward trend in several of the traditional indicators of social wellbeing for men in the society and the ripple effects and negative consequences of this plunge on family life in particular and the Jamaican society in general.

Men at Risk ... what does it mean? This term is now widely used, but with different meanings. What exactly constitutes male marginality? Errol Miller in his book, *Men at Risk* (1991), argues that there are four psychological aspects that make up men’s marginalization. These include *naked violence*, where men display aggression on other victims other than the direct source of their sufferings, example, their family and women. The second aspect is *patriarchal religious beliefs and practices*, where defense of one’s manhood and masculinity by ritual and religious means are practiced. *Sexual prowess and parental irresponsibility* is the third psychological aspect of male marginalization identified by Miller. In this realm, men are seen only as studs that conquer several women sexually and have several children and alienate themselves from parenting responsibilities. The final aspect is that of *acquiescence in self-destruction*. Here, Miller argues, marginal men appear to have internalized forces that seem to be against them and have sought to engage in activities leading to their own demise, the most extreme being suicide. Other activities involve high-risk behaviour, such as unprotected sex.

Chevannes, in his article, *What You Sow Is What You Reap: Violence & the Construction of Male Identity* (1999), purports that the marginalization of men could have its beginnings in the context of the family, but it is within the peer group that the related behaviours are perfected. He argues that within the family construct the male child is the first to suffer deprivation. If resources are scarce and allows only one child to attend school, for example, the girl child would be given preference. According to Chevannes, “Necessity is made into a virtue as suffering becomes a means of producing a hardened man who knows how to survive” (p 3). Chevannes further argues that through the socializing agent of the peer group, the young male detaches himself from parental strains and clings more closely to his peer group, posse or crew. It is within this group that the development of risk taking behaviour takes place and the perfecting of the male identity. This male identity, which is proliferated within the Jamaican context, seeks to create a male population perpetually at risk or marginalized.

Whatever the basis, the young man in Jamaica, more so than the woman, shows negative antisocial behaviours and actions. Men are the main perpetrators of violence. Data from the Economic and Social Survey (2002) indicate that 98.2 percent of the population that was arrested for major crimes, that is murder, shootings, robbery, breakings, rape and carnal abuse, were males. In addition, 97.8 percent of the major crimes committed by youth 15-24 years were committed by men. Among the adolescent population, 14-19 years, male unemployment rates are higher than those for females - 42.7 percent for males compared to

28.5 percent for females. Boys have lower primary and high school completion rates than girls. The result is higher adult illiteracy rates for men, 17.1 percent, than women, 9.3 percent. Similarly, the youth illiteracy rate (14 years and under) is 9.3 percent for males and 2.5 percent females (The World Bank Group- Database for Gender Statistics. dd).

II. Men at Risk and the Women's Centre

The Women's Centre of Jamaica Foundation (WCJF) is world renowned for its pioneering effort to improve the survival chances of pregnant teenagers and teenage mothers through social and material support to ensure continued education for the girl or mother. Why would a Foundation devoted to enabling female adolescents who become pregnant while in school to have healthy babies, continue their education and space their subsequent pregnancies, be interested in men at risk?

Since the inception of the Programme for Adolescent Mothers in 1978, the WCJF has assisted the baby-fathers with counselling, job placement and skill training. This intervention provided opportunities for the young fathers to become involved in the rearing of their children and enlighten counsellors at the Centre of the pervasive lack of sexual and reproductive health knowledge among adolescents. This sent a clear signal that something had to be done to stem the tide of early and unplanned parenting. Many of these young fathers (average age 23 years) were barely literate as they had dropped out of school at the late primary or early secondary level. This prompted WCJF to do the unconventional by starting a structured programme of academic instruction, counselling in sexual and reproductive health with emphasis on male issues for the baby-fathers. UNICEF provided funding for the pilot project that started in January 1999 at three of the Foundation's centres, Kingston, Spanish Town and Montego Bay, and culminated in a workshop for baby-fathers in June of that same year.

In the intervening years, the Government of Jamaica has facilitated the integration of the project for men into the WCJF programme activities. Dubbed the "Young Men at Risk" programme, it is offered at all main centres in the evenings between the hours of 5:00 p.m. to 7:30 p.m. The programme now offered includes literacy in mathematics and English language, sexual and reproductive health including STI/HIV/AIDS, family life education including parenting skills, and the law as it relates to men (age of consent, paternity, etc.) and skill training in technical drawing, electrical installation and tailoring. Over 3,000 young men have been assisted through job placement especially in the hospitality industry, skill training at HEART/NTA, further education at CXC level and training in the armed forces.

Despite the prevailing negative reaction from some young men who feel that they should not attend a "women's centre," we are satisfied that those who access the programme have benefited based on their improved academic status, self-esteem and employment potential. Consequently, the Foundation wants to find ways of broadening and strengthening the programme for men.

III. The Intervention

1. Description

The WCJF, with a grant from the Jamaica Adolescent Reproductive Health Activity (Youth.now) small grant programme, implemented an intervention for young men between 10 and 19 years in two cities - Kingston and St. James. The intervention used peer education, community outreach and condom distribution approaches to realize its goal of increased contraceptive and STI/HIV/AIDS knowledge and improved contraceptive use behaviours among young men at risk in targeted communities. The male peer educators were trained to educate, refer and sell condoms. In addition, the intervention would positively influence male adolescents' perceptions and attitudes about the timing of first sexual intercourse and the selection of sexual partners. The programme's long-term goal was to reduce the number of new cases of STIs among young men in the respective parishes.

2. Selection and training of peer educators

The intervention used young men trained as peer educators to provide information and education, and condoms to their peers and other young men in communities in the two urban areas and to refer them to other service outlets where necessary. Twenty-five young men were selected to be trained from active community-based (religious and secular) youth clubs in the parishes of St. James and Kingston and St. Andrew. A second screening of the group of 50 young men was conducted based on the following criteria:

- Age- between the ages 17 and 25 years;
- Membership in a community-based group or organization;
- Display strong leadership skills; and
- Commitment to stay with the project until its completion.

This process produced 40 potential peer educators. The 40 young men were trained in two groups – one in Kingston the other in St. James. Training took the form of two seminars and a one-week residential training workshop and provided young recruits with knowledge about male sexual and reproductive health, STI including HIV, and contraceptives as well as skills in using a condom and negotiating condom use and in being an effective peer educator. Trained peer educators were deployed to their communities and encouraged to share the information with members of community groups and/or youth organizations to which they belonged. Six months after completing basic training, peer educators were given stocks of condoms for distribution.

IV. Evaluating the intervention components

The effect of the peer outreach and condom promotion intervention on the reproductive health knowledge, attitudes, behaviours and practices of young men at risk in the two cities was assessed in two ways: (i) using data from baseline and endline surveys conducted in communities served by the peer educators; and (ii) using condom distribution statistics kept by peer educators. Qualitative observations and reflections from the peer educators themselves also provided useful insights into the effect of the intervention on the peer educators.

1. Methodology for baseline and endline surveys

A multistage sampling design was used to select survey respondents. At stage one, a sample of 25 groups was randomly selected from a list of active community-based and/or Christian

youth clubs within each of the two parishes. At the second stage of sample selection, a random sample of 20 young men was selected from each group to give a total survey population of 500 young men. A similar methodology was used to select the sample for the follow-up or endline survey.

Questionnaires were distributed to potential respondents by trained research field staff. The St. James baseline survey was completed in July 2002. Plans to conduct the baseline in Kingston had to be abandoned because of practical difficulties. The endline survey in St. James was fielded in January 2004, but community violence and bad weather both influenced the outcomes. A total of 420 completed baseline survey questionnaires were returned; 144 endline survey questionnaires were completed. Survey data and information were gathered on socioeconomic characteristics, family characteristics, physical development, sexuality and wellbeing, attitude and knowledge of contraceptive methods, sexual activity experience and fertility preference and lastly assessment of health services.

2. Data Analysis

Survey data collected in St. James were analysed using the Statistical Package for the Social Sciences (SPSS) software, Version 11.5. In addition to frequency tables, the data from the baseline and endline surveys were analysed to answer the following questions:

- Does one's educational level affect knowledge on HIV and contraceptives?
- Is there a relationship between educational level and age of first sexual intercourse?
- Is there a relationship between church attendance and knowledge on HIV?
- Is there a relationship between church attendance and age of first sexual intercourse?

Non-parametric tests of significance (chi-square) were used to assess the strength of the relationship between variables. The value used for level of significance was 0.05, that is, all values less than 0.05 are considered statistically significant.

V. Survey Findings

1. Description of the samples

a. Young men

A total of 420 young men completed baseline survey questionnaires. The average age of young men replying was 17.3 years. For the 414 respondents for whom data on age was available, the minimum age was 12 years; the maximum age was 30 years. Approximately 60 percent of the respondents reported attending church at least once per week. Just under half, 48.1 percent, had at least a secondary level education; with 10.7 percent gaining post-secondary level education.

Of the 144 young men interviewed at endline, the ages ranged from 13 (2 men) to 27 years (1 man), with a mean age of 19 years. Just over half (54.5%) reported attending church at least once weekly. More than half (56%) of the respondents had secondary education. One out of every ten (9.8%) young men surveyed at baseline (or 7.1% of the boys who were sexually active) had fathered a child. The average age of fatherhood for this group was 18.2 years. In contrast, 15 (10.6%) of the young men in the endline survey (approximately 22% of the sexually active) had ever made a girl pregnant. Mean age at becoming a father was 20 years. Only 14.4 percent of the

respondents in the baseline survey reported ever having an STI, compared with 40 percent of the follow-up survey sample.

More than half (57%) the respondents in the baseline survey reported being involved in a club or community group; 82 percent of those surveyed at follow-up report being part of a group or club. Two thirds (64%) of the baseline respondents assisted in community activities, e.g. Labour Day or community clean-up, compared to 56 percent of the endline respondents. Respondents in both surveys were also involved in sports. Football was by far the most popular sport with 70 percent and 83 percent involvement among young men surveyed at baseline and endline respectively. Cricket, basketball and athletics were the next most popular sports. Two-thirds (66.1%) of the young men in the baseline sample and three out of four respondents in the follow-up survey were happy with their physical appearance. Data for several of the key descriptive variables are summarised in Table 1.

b. Family Characteristics

The majority of respondents in both surveys lived with their mothers. The results show that mothers' average age (baseline) was approximately 41 years (40.8) compared to 43 years for the endline sample. The average age of fathers was 46 years (45.9) at baseline and 48 years for the end line sample. How old were respondents' parents when they had their first children? Young men surveyed at baseline report their mothers' mean age when she had her first child was approximately 19 years (19.4), while their fathers' mean age at fatherhood was approximately four years older - 23.2 years. The youngest age of fathers attaining fatherhood was 14 years and oldest age was 38 years. A similar four-year difference was observed in the reports from respondents in the endline survey.

Baseline and endline data indicate that mothers' educational levels were different than fathers' educational levels. In the baseline survey sample of men, half (50.7%) of the mothers had secondary level education compared to 44 percent of the fathers. A similar pattern was observed for the endline sample of young men where 58 percent of fathers versus 49 percent of mothers had secondary level education. A greater proportion of fathers than mothers, however, had post-secondary level education. Employment data showed that the mothers and fathers of the young men were mostly employed by someone else - with 59.4 percent and 54.9 percent employment at baseline and endline, respectively. Fathers were more likely than mothers to be self-employed. Table 1 provides a summary of selected findings from baseline and endline surveys.

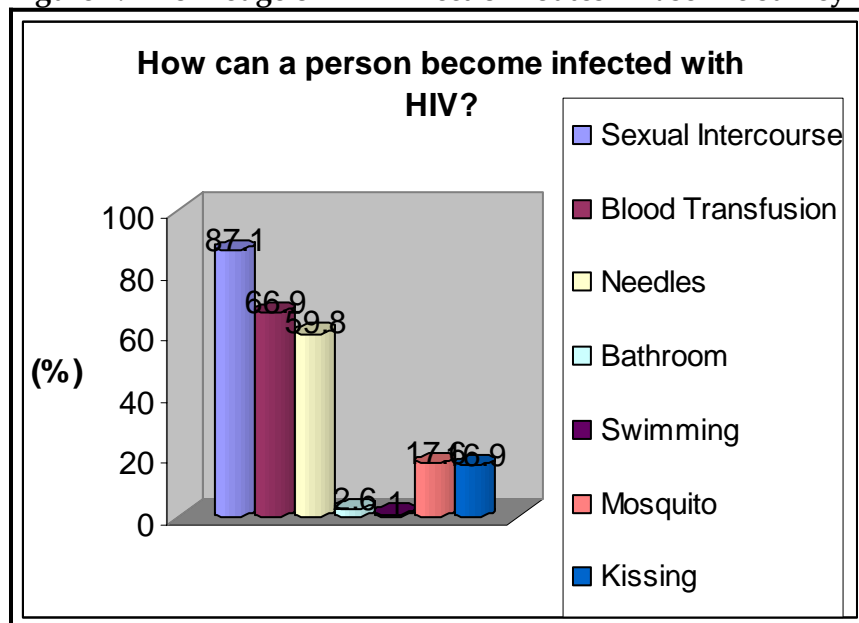
Table 1: Summary of Baseline & Endline Survey Findings – Selected Variables

Variable	Baseline Survey		Endline Survey	
Sample size for Survey	N= 420		N=144	
Mothers' mean age at 1 st birth	19 yrs	n= 199	19.7	n=84
Mothers' mean age	40.8 yrs	n= 246	43	n=79
Fathers' mean age at 1 st birth	23.2 yrs	n= 111	22.9	n=51
Fathers' mean age	45.9 yrs	n= 177	47.9	n=64
Mean age of boys	17.3 yrs	n= 414	19.0	
Respondent's mean age at first sex	13.3 yrs	n= 152	13.2	n=68
Average times boys had sex in last 6 months	7.7	n= 99	9	
Mean # sexual partners in last 6 months	2.5	n= 152	3	n=68
Mean # sexual partners over lifespan	6.4	n= 159	9	
% attending church at least once per week	55.9	n= 395	54.5	N=143
Boys' education level				
Primary	41.2 %		29.2%	
Secondary	48.1 %		56.3%	
Post-secondary	10.7 %		14.6%	

2. Reproductive health knowledge

Comparison of the baseline and endline data on HIV knowledge indicates important improvements over time. A large proportion (87.1%) of the boys knew that HIV can be transmitted through unprotected sexual intercourse with an infected person. More than two out of three (66.9%) knew that HIV transmission can occur through blood transfusion and 59.8 percent knew about transmission through IV drug use (needles). It should be noted that 17.6 percent and 16.9 percent of the boys thought that HIV could be contracted through the bite of a mosquito and through kissing respectively. These baseline findings are presented in Figure 1. Knowledge scores of young men surveyed at endline were better than at baseline. All men at endline knew that HIV is transmitted through unprotected sexual intercourse with an infected person, 96 percent indicated transmission through blood and 92% through contaminated needles. The bathroom, mosquito bites and kissing were identified as HIV transmission modes by 2.1 percent, 2.8 percent and 8.3 percent, respectively.

Figure 1: Knowledge of HIV infection routes – Baseline survey



Multiple responses were allowed

Further analysis of the HIV knowledge variables indicate that at baseline approximately 76 percent of the young men gave correct answers about transmission (i.e., sexual intercourse, blood transfusion and needles/syringes) while at endline, 96.3 percent gave correct answers. This difference is statistically significant.

3. Knowledge of contraceptives

Table 2 shows respondents' knowledge about contraceptives reported at baseline and endline. Approximately 92 percent of the boys reported knowing about condoms, 64 percent about pills and 42 percent about withdrawal. Only 25 percent reported knowing about the emergency contraceptive pills. Knowledge of contraceptives at endline was significantly (statistically) improved for most methods.

Table 2: Percentage who have heard about contraceptive methods

Contraceptive Method	Baseline (%)	Endline (%)	Statistical test
Male Condom	91.7	98.6	
Pills	64.3	95.1	
Injectables	51.0	82.6	
Withdrawal	41.7	82.6	
Tubal ligation	34.3	77.1	
Vasectomy	33.6	75.7	
Emergency contraceptive pill	25.0	71.5	
Jelly	16.7	46.5	
IUD	15.7	48.6	
Rhythm	15.2	35.0	
Norplant	4.6	13.2	

Multiple responses were allowed

4. Attitudes of Men at Risk

Who makes the decision to use pregnancy or STI protection at first intercourse? Responses to this question at baseline are summarised in Table 3. More than one third (39.7%) of the respondents reported that they made the decision. In 24.1 percent of the cases, the woman decided. In 63.2 percent of the cases, however, the decision to use contraceptive/ protection at the last sexual intercourse was made by both partners. In the sample of young men surveyed at endline, 5.6 percent report that the woman made the decision to use a contraceptive/ protection at their first sex, 47.2 percent the man made the decision and in 47.2 percent of the cases both partners decided. At last sexual intercourse, the decision to use a contraceptive/ protection was taken in 5.1 percent of cases by the woman, in 33.3 percent of the cases by the man and in 61.5 percent of the cases by both partners.

Table 3: Decision about contraceptive use – who decides (Baseline survey)

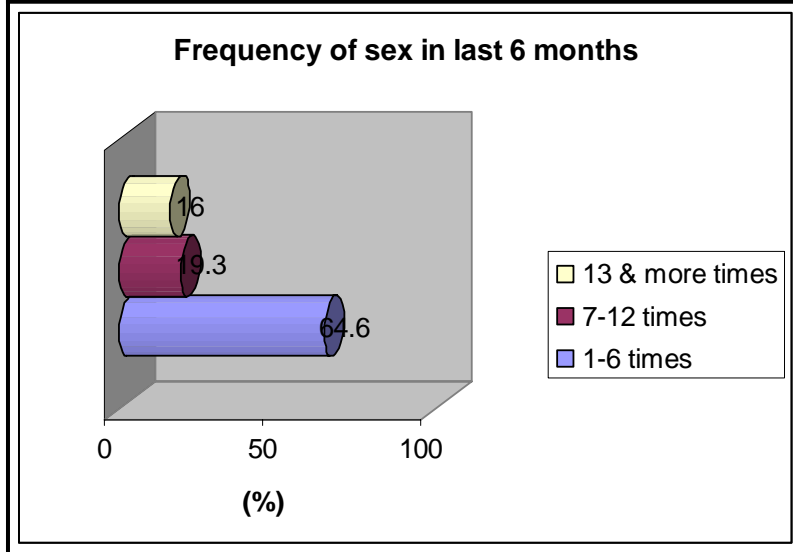
	Who decided the use of a contraceptive the 1 st time you had sexual intercourse	Who decided the use of a contraceptive the last time you had sexual intercourse
Girls	24.1 %	13.8 %
Boys	39.7 %	23.0 %
Both	36.2 %	63.2 %
N	116	196

Multiple responses allowed

5. Practices/ Behaviours of Men at Risk

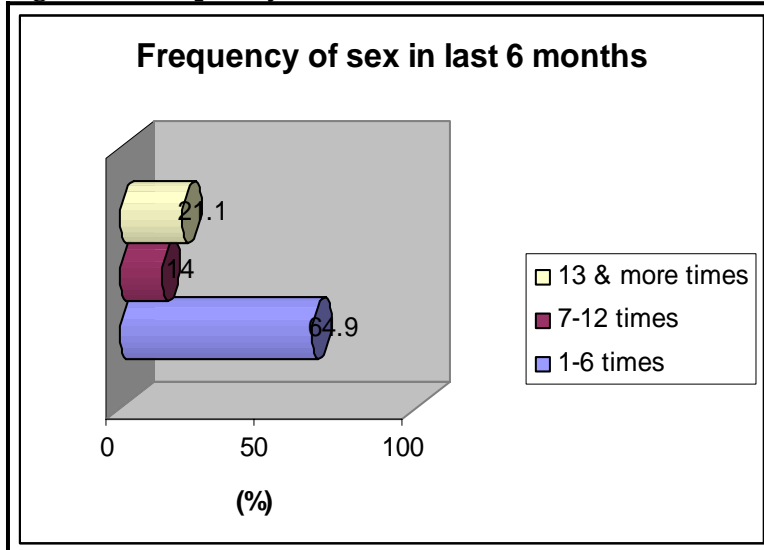
Of the total sample of 420 young men surveyed at baseline, 36.2 percent (152) reported ever having sex. Mean age at first sex for those who were sexually active was 13.3 years. In comparison, close to half (47.2%) of the sample of young men participating in the endline survey were sexually active. But the mean age at first sex for that group was about the same - 13.2 years. Over the six-month period before the baseline survey, 41 percent of the respondents had had sex. The average number of times was eight and the mean number of sexual partners over the same period was two. On average, the young men at endline had sex nine times in the six months with an average of three partners.

Figure 2: Frequency of sex in last six months – Baseline survey



n= 99

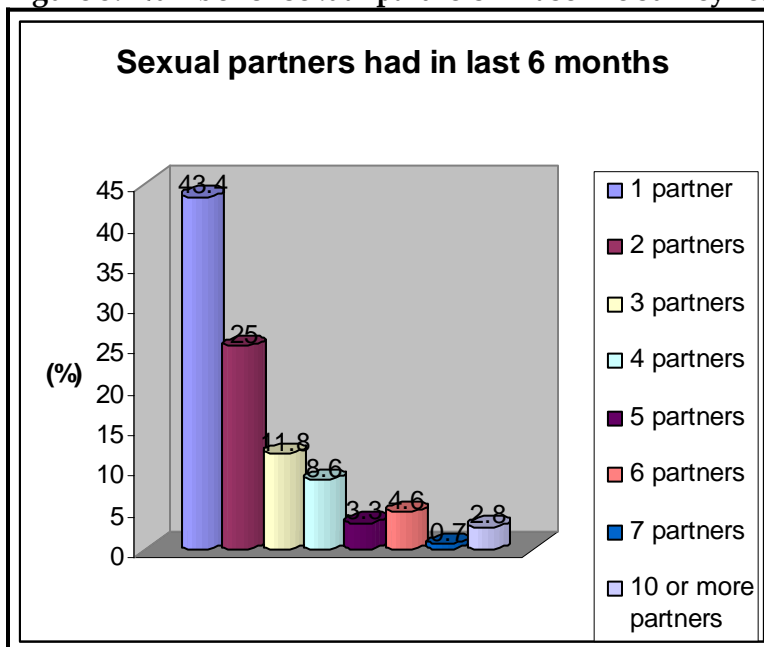
Figure 2a: Frequency of sex in last six months – Endline survey



n= 57

A very sensitive measure of whether young men are adopting safe sexual behaviours, and therefore, an indicator of the impact of behaviour change communication, is the number of sexual partners a young man has in a six-month period. Forty-three percent of the baseline survey respondents had only one partner. Stated another way, 57 percent had more than one sexual partner in the six months prior to the survey. The mean number of sexual partners over the same period for men in the baseline survey was two. Details are shown in Figure 3. On average, the young men surveyed 18 months after the intervention was implemented had sex nine times in the six months preceding the survey with an average of three partners. The mean number of sexual partners over the lifespan for baseline survey respondents was six compared with nine sexual partners for young men in the endline survey.

Figure 3: Number of sexual partners - Baseline survey results



6. Condom use behaviours

Peer educators were trained to promote consistent condom use as a safer sexual practice and to demonstrate how to safely put on a condom and to dispose of used condoms. In addition, educators were condom suppliers. Condom use behaviours were measured in each survey in terms of respondent: (i) ever used a condom; (ii) use of condom at last sexual intercourse; (iii) knows how to use a condom; and (iv) knows where to get condoms. Condom use at first sex and most recent sexual intercourse was very high at both baseline and endline. A majority (98.3% and 97.3%) of the sexually active young men at baseline and endline reported using a condom. During most recent sex (last sexual intercourse), 94.4 percent of young men surveyed at baseline compared with 98.7 percent surveyed at endline had used a condom.

7. Knowledge of how to use a condom

The surveys show that young men are using condoms. Are they using them correctly? Correct use was measured in the survey by asking men to report the steps that are taken

when using a condom. Close to 80 percent of men surveyed at baseline knew how to correctly use and dispose of a condom. Close analysis of the responses, Table 4, indicate that although men said they know how to use a condom, just over half of the respondents at baseline knew they should leave a space at the end of the condom and less than half of them knew the correct procedure to remove the used condom. This knowledge had improved at endline. More than 90 percent of men surveyed knew how to use a condom correctly.

Table 4: Percent of respondents who know how to use a condom

Steps in using a condom	Responses (baseline) (%)	Responses (endline) (%)
Squeeze end / tip of condom	56.9	93.8
Unroll onto erect penis	69.0	97.9
After ejaculation, hold base of condom then remove	45.0	95.8
% with knowledge of correct condom use	79.8	96.0

Multiple responses allowed

Where are young men accessing condoms? Details are provided in Table 5. The pharmacy and friend were the sources reported by most young men at baseline. At endline, 45 percent of the sexually active young men were reporting “other” sources for their condoms. These “other” sources were the peer educators who are also condom distributors.

Table 5: Respondents’ condom sources

	Baseline Survey		Endline Survey	
	Contraceptive source (1 st sex) (%)	Contraceptive source (last sex)	Contraceptive source (1 st sex) (%)	Contraceptive source (last sex)
Pharmacy	34.1	37.8	61.1	38.8
Public health centre	4.5	5.2	8.3	8.8
Public hospital	5.7	2.1		1.3
Private hospital	2.3	1.6	2.8	1.3
Private clinic	4.5	3.1		
Private doctor/nurse	1.1	0.5	5.6	2.5
Friend	45.5	17.6	11.1	2.5
Shop/supermarket		31.6		
Other	2.3	0.5	11.1	45.0
	n= 88	n= 193	N= 36	n= 80

8. Condom distribution statistics

All peer educators in St. James and Kingston were trained how to distribute condoms and demonstrate condom use. Condom distribution started in March 2003 with 12,200 condoms supplied by NFPB. By the end of the intervention in mid-2004, peer educators in St. James had distributed a total of 5,368 condoms. Peer educators in Kingston distributed 4,392 condoms in the same time period.

9. Negotiating sex

Young men who reported ever having sex were asked: What did you do to encourage females/girls to have sexual intercourse with you? The results presented in Table 6 show that in 31 percent of the cases the boys asked and the girls agreed to have sexual intercourse; 6.9 percent of the boys stated they actually forced the girl to have sex with them. Another 4 percent tricked the girls into having sex. In the endline sample of young men, 97.2 percent said the girl agreed to have sex, 6.9 percent admitted to forcing the partner to have sex, and 5.6 percent tricked the partner into having sex.

Table 6: Methods reported by boys to get sex from girls

Methods used to encourage sexual intercourse	Baseline survey % of responses	Endline survey % responses
Nothing (Boy asks, girl agrees)	31.0	97.2
Sweet talk	10.5	13.2
Force	6.9	6.9
Trickery	4.0	5.6
Threats	0.7	2.8
Convincing (with money and gifts)	3.8	4.9
N	420	144

Multiple responses allowed

Survey data were also analysed to answer the following questions:

- Is there a relationship between age and knowledge of HIV?
- Is there a relationship between age and contraceptive knowledge?
- Does one's educational level affect knowledge on HIV and contraceptives?
- Is there a relationship between educational level and age of first sexual intercourse?
- Is there a relationship between church attendance and knowledge on HIV?
- Is there a relationship between church attendance and age of first sexual intercourse?

10. Relationship between age and knowledge of HIV

There was a statistically significant and positive relationship between the age of the young men and their knowledge on HIV. As the age group of boys increased, the likelihood of knowing about HIV also increased. See Table 7.

Table 7: Relationship between respondents' age and knowledge of HIV transmission

Knowledge on HIV	Age Groups (years)			$\chi^2=$ 19.985 C.C = .214
	< 14 yrs	15-19	> 19	
Poor	22.4	8.1	8.2	
Average	38.8	33.5	27.8	
Good	38.8	58.5	63.9	
Total %	100	100	100	

Pvalue = .001

A significant relationship was also found between age of young men and knowledge of contraceptives. The findings suggest that as age increases, knowledge of contraceptives among young men also increased. The age group which had the highest percentage of boys who had poor knowledge on contraceptives was the below 14 age group.

Table 8: Relationship between respondents' age and knowledge of contraceptives

Knowledge on Contraceptives	Age Groups			$\chi^2=$ 31.744 C.C = .266
	Below 14 yrs	15-19	20-30	
Poor	85.9	61.0	47.4	
Average	12.9	25.4	32.0	
Good	1.2	13.6	20.6	
Total %	100	100	100	

Pvalue = .000

11. Relationship between level of education and knowledge about HIV and AIDS

In both samples of young men, the analysis shows there was no statistically significant difference in the knowledge about HIV and AIDS for young men who have primary education and those who have secondary or tertiary education.

12. Relationship between educational level and age of first sexual intercourse

A significant positive relationship exists between educational level and age at first sexual intercourse for young men in the baseline sample. The majority (54%) of young men who had only primary school education had their first sexual intercourse before their twelfth birthday. The majority (52%) of young men who reported having a post-secondary level of education had their first sexual activity at age 15 or older. See Table 9.

Table 9: Association between educational level and age of first sexual intercourse (Baseline survey)

Age of 1 st sexual intercourse	Educational level			$\chi^2 = 16.519$ CI = .311
	Primary	Secondary	Post-secondary	
10-12 years	54.3	34.4	13.0	
13-14	37.1	37.5	34.8	
15 and older	8.6	28.1	52.2	
Total	100	100	100	

p value = .002

Similarly, a statistically significant relationship also existed between men's educational level and their age at sexual debut. Table 10 shows that 87.5 percent of males who started having sex between the ages of 10-13 had only achieved a primary level education while those who had attained a post-secondary education had begun having sex at a later age, between 14-19 years.

Table 10: Association between educational level and age of first sexual intercourse (Endline survey)

Age of 1 st sexual intercourse	Educational level			$\chi^2 = 9.543$ CI = .351
	Primary	Secondary	Post-secondary	
10-13 years	87.5	54.5	25.0	
14-19 years	23.5	45.5	75.0	
Total	100	100	100	

p value = .008

13. Is there a relationship between church attendance and knowledge on HIV?

Church attendance was relatively high at both surveys with more than 50 percent of the each sample attending church at least once weekly. Knowledge of HIV transmission methods was high in both samples and although knowledge scores at endline were better than at baseline, there was no relationship between church attendance and knowledge about HIV transmission.

14. Is there a relationship between church attendance and age of first sexual intercourse?

Although there was a positive association between age at first sex and educational attainment, there was no such relationship with church attendance. A young man's church attendance behaviours did not seem to be associated, positively or negatively, with the timing of his first sexual encounter.

15. Effects of the training on peer educators

Peer educators were conscious of the effect of the training on their personal lives, their peers, families and communities. Some personal gains noted are as follows:

- Empowerment to initiate change among their peers;

- Gained the respect of their communities “the person to go to for counselling”;
- Some saw the need to further their education;
- More participation in training workshop on HIV/AIDS;
- The training has helped to dispel certain myths and misconceptions;
- Approach to conflict management has improved, e.g. avoiding situations which encourage violence;
- Reduction in smoking and use of drugs;
- One stated that the training has such a profound effect on him that has learnt to talk less and listen to others more; and
- Some of the young men involved in the training were unemployed, had low literacy level and low self-esteem, displayed unacceptable social behaviour. By the end of the training, there were obvious improvements in these areas.

WCJF hosted recall/review workshops in St. James on Friday, November 5, 2004 and in Kingston on Friday, November 12, 2004. The 30 young men who attended showed marked improvement in their personal development, knowledge on SRH issues and competence in communication. Of particular importance is the fact that all the 30 young men (22 St. James, 8 Kingston) are gainfully employed. Some are also attending school after work. One young man is preparing to sit CXC in June 2006.

Some personal gains noted by participants:

- One young man related the story of being stoned by the father of a pregnant schoolgirl who sought his advice. He said he is able to deal with the situation calmly instead of violently, as he would have done before the training.
- Another reported that he now has the confidence to speak to his peers about any problems without fear of ridicule.
- Yet another is so empowered that he organizes training sessions using the topics discussed in the initial training. This is to ensure that there is continuity. He is a bus driver who is not always present at meetings, etc.

VI. Limitations

Like all evaluations that rely on field-based surveys, this series of two surveys was severely hampered and consequently the extent to which a thorough and complete evaluation of the intervention can be done is questioned. First, plans to conduct the surveys in Kingston and St. Andrew had to be scrapped. Secondly, community violence in St. James affected the completion of the endline survey in two ways:

- (i) It made fieldwork impossible, as field workers were reluctant to visit communities because of the violence.
- (ii) Residents fled their homes – the sample size of the endline sample was therefore severely affected.

Notwithstanding the events in St. James that resulted in under-sampling at endline in St. James, WCJF can get a good sense of the effects of the intervention in that city by triangulating data from three sources: (i) baseline and endline survey - data collected from the 421 and 141 young men; (ii) service statistics on condom sales generated by the peer educators; and (iii) qualitative information from peer educators and WCJF personnel in the St. James Centre.

VII. Discussion and Conclusions

The findings of these two surveys in St. James give us hope and, at the same time, cause for worry. The positive and hopeful signs are in the changes in reproductive health knowledge and attitudes of young men in the Montego Bay community. The findings suggest that over the period of the intervention young men's knowledge of contraceptives, HIV transmission and use of condoms improved significantly.

There is indeed a positive relationship between respondents' age and their knowledge of HIV/AIDS. The older they are the more they know about HIV/AIDS. Although at face value the relationship seems positive, the reality is that more needs to be done to provide the vital education about HIV/AIDS earlier in the lifespan. If boys are becoming sexually active at age 13 years, when they are in all-age or lower grades of secondary school, then they need to have the knowledge and skills to protect themselves, and their partners, from infection and pregnancy. That set of skills may also serve to empower them to be the ones to decide that protection needs to be used at all sexual encounters. It could be recommended therefore that creative mechanisms be put into place to integrate sexual and reproductive health in the education system as early as Grade 5.

Although there were important and statistically significant changes in knowledge between baseline and endline, changes in behaviour were not as evident. The significant changes in the knowledge and attitude variables between baseline and endline and the lack of change in the behaviour variables confirm what other research in the field of reproductive health has found – that, in the short term, it is easier to change knowledge of STIs and HIV/AIDS than to change sexual practices. The findings also reflect the difficulty of changing behaviour among adolescents and imply that these behaviours are influenced by a large number of factors, factors that go beyond knowledge and attitudes related to reproductive health alone. Therefore, it is safe to say that in order to reduce the sexual risk among young males, both the knowledge of STIs including HIV/AIDS and contraceptives must be the focus. This approach must be geared not only to adolescents, but also to those just entering adolescence.

Notwithstanding the limitations of this evaluation, this intervention provides hope for men at risk of HIV/AIDS/STI and unplanned fatherhood. Although changing risk behaviours is difficult, it is not impossible. We can achieve it one young man at a time – by training large numbers of young men as peer educators and having each young man reach his peers with what he knows as well as through what he becomes – a positive role model.

References

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